SPECIAL NEEDS/CHILD PLACEMENT QUESTIONNAIRE

Welcome to IMA-E Child/Youth Services programs! If your child should have a special need, prior knowledge will allow us to make appropriate adjustments to our program and provide training to the staff before your child's first day.

Child's Name:_____ Today's Date:: _____
Child's Date of Birth:_____ Sponsor's Name:_____
Sponsor's Unit: _____ Sponsor's Home & Duty Phone Nos:_____/_____

1. Does your child have any of the following conditions?

	YES	NO		YES	NO
Developmental delays, explain:			Asthma/Respiratory Problems		
Visual Problems/Blindness (Do not check this box if your child only wears glasses)			Speech/Language Delays		
Hearing Problems (Check this box if your child has had Tubes placed) Explain:			Allergic Reactions Explain:		
Physical Disability. Explain:			Behavioral/Conduct Concerns		
Sickle-Cell Disease (Do not check this box if your child Has only Sickle Cell Trait)			Heart Problems (Do not mark this box if your child has a functional or innocent heart murmur)		
Kidney Problems. Explain:			Diabetes		
Epilepsy/Seizures			Attention Deficit/Hyperactivity (ADHD/ADD)		
Autism/PDD			Other(s) Please Specify:		

2. Is your child taking medication for his/her condition, if so please specify:

3. Is your child receiving any services from EDIS (formally EFMD) Early Intervention or Pediatric Behavioral Medicine?
___Yes___No If yes, which agency and please explain:

___Yes ___No Is your child on an IFSP or an IEP?

4. Is your child enrolled in a DODDS Developmental Preschool? ___Yes ___No If yes please explain:

5. Is your child enrolled in an Exceptional Family Member Program (EFMP)? ___Yes ___No If yes please explain:

_____ _____
PRINT Sponsor's Name (state rank if applicable) Sponsor's Signature

For PRIVACY ACT STATEMENT see DA Form 4719-R, July 1989.

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(OFFICE USE ONLY) Date received:_____

History of Special Need/Medical Condition: Telephone contact date & time_____

_____
_____
_____
_____
_____

Recommendation: a. Admit/No Significant modifications needed b. Admit w/Care Plan Training date _____ c. Hold & schedule SNRT Date/Time _____

_____ _____ _____
CYS/CH NURSE Date Yes/No EFMP Manager Date Yes/No CYSD Coordinator Date Yes/No

Copy to CYS: ☐ Copy to EFMP: ☐ Copy to CHN: ☐ OS-log entry: ☐ OS-child's file: ☐